luck with it than others (I among them). Stereotaxic thalamotomy is now only rarely being done for lateralized tremor or rigidity, and the operation does not help the more bothersome problems of bradykinesia and poor balance.

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Duty to Report Child Abuse

"MALPRACTICE LIABILITY FOR FAILING TO REPORT CHILD ABUSE" is a reprinting of an article which appeared in Volume 49, No. 2, of the *California State Bar Journal* (March-April 1974). The article represents the work and research of Richard J. Kohlman, Esq., over the past one and one-half years, and it deals with the second lawsuit in California over the past two years for a failure to report. In legalese, it is an explanation of the doctrine of negligence per se and common law medical malpractice enabling an attorney to file a suit in the civil courts on behalf of an abused child. For the physician it represents a clear warning: a failure to report suspected child abuse may mean civil liability.

While both suits have been brought in California under California law, the implication is quite strong that this type of suit would be successful in any state. The obligation of physicians to report suspected cases of child abuse, as in California, is found in the law of every state, the District of Columbia, Puerto Rico and the Virgin Islands. Coupled with this obligation is the potential civil liability for all subsequent injuries to the child when there is a failure to report suspected cases of abuse.

As a physician I would like to add that the current number of children reported for significant physical abuse in the United States is 380 per million population per year. This amounts to some 70,000 children annually. The initial mortality is 5 percent; permanent brain damage due to subdural hematoma occurs in another 5 percent. There are few diseases afflicting our children with such an incredible morbidity and mortality. Physicians, their nurses and assistants have a wonderful opportunity prenatally and postnatally and in the routine care of young children to predict, prevent and treat this devastating social and medical problem afflicting so many families.

Physicians who feel that they are doing something "against the parent" by notifying suspected cases of child abuse and aiming for early intervention to safeguard the children, should instead think of doing something "for the family." Few (less than 10 percent) of battering parents are aggressive sociopaths, paranoid schizophrenics, or plain "cruel people who torture children," although there are such persons, often impossible to treat successfully. In such cases the children have to be removed to safety and sometimes parental rights must be terminated. On the other hand, the other 90 percent of families involved respond beautifully to intensive mothering care given by sympathetic lay therapists; and they can be helped by joining Parents Anonymous, or by establishing a trusting relationship to a physician, to a public health nurse, to a social worker or any other helping person. In the great majority of cases their children can be safely returned in less than eight months after intervention begins. Clearly, therefore, the outlook is excellent and the physician's duty is unmistakable.

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Brain Abscess

THE SYMPOSIUM ON BRAIN ABSCESS presented by Drs. Yoshikawa and Goodman in this issue is an excellent review. It touches on a most appropriate set of questions. One of these is the steady mortality rate of brain abscess over the last few years. The authors make clear that there are two specific reasons for continuing high mortality. First, a brain abscess is a space occupying lesion and the mortality is more closely related to that than to the infectious aspect. Second, the lack of prompt and accurate diagnosis contributes heavily to the

problem. They point out the rapidity of worsening in patients with a brain abscess. The clinical features of the disease and methods for diagnosing it are outlined.

The dangers of lumbar puncture receive both negative and positive emphasis. As meningitis is rare with brain abscess, the information obtained from lumbar puncture is of minimal value in the diagnosis. The downhill course after puncture is well documented in the authors' series. Because of these points, the authors decry the use of the lumbar puncture—a position most neurosurgeons heartily approve.

The efficiency of electroencephalogram (EEG), brain scan and angiography in confirming and localizing the abscess is mentioned. Unfortunately, EEG's and brain scan may not be available at night or over week-ends. These procedures should be available so that patients who might be harboring an abscess may have a noninvasive procedure done soon after admission to hospital. A cautious physician may be reluctant to use angiography without the additional evidence offered by these techniques. The delay may prove disastrous for the patient.

While neurosurgeons might argue about the precise technique of surgical treatment, the importance of the likelihood of multiple or daughter abscesses is discussed. Both can be missed by needle aspiration technique. A patient known to have a brain abscess must be suspected of having another abscess adjacent or remote from the proven abscess if improvement does not promptly occur after surgical therapy.

A useful and complete review of the bacteriology of brain abscess is given. Attention is drawn to the importance of anaerobic culture techniques to insure full and accurate information. Of more importance is the emphasis on smearing and staining specimens of pus obtained at operation. A great amount of information can be obtained by that old procedure. Exotic and opportunistic organisms may be shown only by smear.

A succinct review of antibiotic drugs and appropriate use is included.

Brain abscess should be a disease with a very high cure rate. It is disappointing to note that such is not the case. Information contained in the symposium should help toward that promise.

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Reaching the Unreached With Health Care

SINCE IT HAS BECOME well established that medical care can improve one's chances for continuing health and longer survival, it is not only worthwhile but important to see what can be done about reaching the unreached with it. During the last decade there have been enormous efforts in both the public and private sectors to accomplish this. The approaches have been to reduce or eliminate the financial barriers, to tinker with the delivery system or consider replacing it with another, and to try to tell the public what is good and what is bad for its health, even to try frightening people. While there has been some progress, the problems of reaching the unreached with health care have by no means been solved.

It is suggested that the unreached may be considered in three categories. First there are the under-served in geographically remote areas, sometimes referred to as the rural ghettos. Then there are the under-served in the urban ghettos who may or may not be in close proximity to every kind of health care resource but still do not get the care they need. And then there is a very large and generally overlooked group, the under-served among educated, economically self-sufficient persons who are quite capable of getting health care for themselves, but who may feel they are perfectly healthy and not in need of care, or who for some other reason may not choose to avail themselves of it. It is quite clear that there is more to the problem than is likely to be solved by removing financial barriers, by restructuring the delivery system, or by imposing a period of involuntary service upon young physicians in partial repayment of the cost of their education, as is now being proposed in some government circles.

Perhaps the time has come to consider some other factors which so far may not have been given their due, and yet affect each of the three categories of under-served to a greater or less extent. One of these is cultural attitudes toward health care. These vary among individuals and within each category of under-served. It is fallacious to